

Basic Health and Medicaid Eligibility Review

Announcement: On July 1, 2011, Medicaid left the Department of Social and Health Services (DSHS) and merged with the Health Care Authority (HCA).

Section 1: Household Information		Complete this section for member/applicant and legal spouse, even if not requesting coverage.			
What language and dialect do you speak?		Check here if you need an interpreter <input type="checkbox"/>		WA Driver License or ID Number*	
Member/applicant's Last name		First name		MI	Social Security number
Applicant signature (required)		Race (see examples below)**		Tribe name (for American Indians, Alaska Natives)***	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Requesting coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Receiving state medical benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Client ID number (if known)	
Street address required; must attach proof*		Apt. #	City	County	State ZIP Code
Mailing address or P.O. Box (if different from above)			City	County	State ZIP Code
Home phone number () ()		Other phone number () ()		Marital status (check one) <input type="checkbox"/> Single <input type="checkbox"/> Legally separated <input type="checkbox"/> Legally married – date of marriage: _____	
Check the box if you (all that apply):		<input type="checkbox"/> Have other coverage	<input type="checkbox"/> Have health problems expected to keep you from working for 12 months		
<input type="checkbox"/> Need help with unpaid medical bills for any of the past three months		<input type="checkbox"/> Received a positive result from a pregnancy test—Due date: _____			
Do you prefer to be contacted by: <input type="checkbox"/> Email or <input type="checkbox"/> Postal mail		Email address			
Complete this section for legal spouse					
Spouse's Last name		First name		MI	Social Security number
Applicant signature (required)		Race (see examples below)**		Tribe name (for American Indians, Alaska Natives)***	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Requesting coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Receiving state medical benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Client ID number (if known)	
Street address required; must attach proof*		Apt. #	City	County	State ZIP Code
Mailing address or P.O. Box (if different from above)			City	County	State ZIP Code
Home phone number () ()		Other phone number () ()		Marital status (check one) <input type="checkbox"/> Single <input type="checkbox"/> Legally separated <input type="checkbox"/> Legally married – date of marriage: _____	
Check the box if you (all that apply):		<input type="checkbox"/> Have other coverage	<input type="checkbox"/> Have health problems expected to keep you from working for 12 months		
<input type="checkbox"/> Need help with unpaid medical bills for any of the past three months		<input type="checkbox"/> Received a positive result from a pregnancy test—Due date: _____			

Section 2: Legal Dependents		(If more than two, list on a separate sheet or copy this page.)			
List all of your legal dependents up to age 26, even if you do not want coverage for them or they are not living in your home. Dependents attending school out-of-state must include proof from the school. (Refer to the <i>Applying for Basic Health</i> booklet for more information.)					
1	Last name	First name		MI	Social Security number
Place of birth City/State		Relationship to applicant <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____		Birth date	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Requesting coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Is dependent a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is dependent attending school out-of-state? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, send proof of registration.		Race (see examples below)**		Tribe name (for American Indians, Alaska Natives)***	
Check the box if you (all that apply):		<input type="checkbox"/> Have other coverage	<input type="checkbox"/> Have health problems expected to keep you from working for 12 months		
<input type="checkbox"/> Need help with unpaid medical bills for any of the past three months		<input type="checkbox"/> Received a positive result from a pregnancy test—Due date: _____			
Is dependent living in the home full time? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide the dependent's address below.					
Address		City	County	State	ZIP Code
2	Last name	First name		MI	Social Security number
Place of birth City/State		Relationship to applicant <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____		Birth date	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Requesting coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Is dependent a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is dependent attending school out-of-state? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, send proof of registration.		Race (see examples below)**		Tribe name (for American Indians, Alaska Natives)***	
Check the box if you (all that apply):		<input type="checkbox"/> Have other coverage	<input type="checkbox"/> Have health problems expected to keep you from working for 12 months		
<input type="checkbox"/> Need help with unpaid medical bills for any of the past three months		<input type="checkbox"/> Received a positive result from a pregnancy test—Due date: _____			
Is dependent living in the home full time? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide the dependent's address below.					
Address		City	County	State	ZIP Code

* If you provide a valid Washington State Driver License or Identification Card number, Basic Health may accept it as proof of residence without you sending a copy of the document.

**Race and ethnic background information is voluntary.

Race examples: White, Black or African American, Hispanic or Latino, Pacific Islander, American Indian, Alaska Native, or any combination of races.

***Send proof. See the *Applying for Basic Health* booklet for acceptable forms of documentation.

Section 3: Other Biological Parent (If living in your home)

Do you want coverage for a dependent whose other biological parent is not legally married to you, but is living in your home? Yes No

If the other biological parent wants Basic Health coverage, he or she must submit a separate form.

If you checked "yes," you must fill in the following information about that parent and attach proof of this person's last 30 days income.

Name of other biological parent (Last name, First name, MI)			Social Security number
Birth date	Gross monthly income (before taxes)	Daytime phone number ()	Employer's phone number ()
Employer/company name		Employer's address	
List the names of this parent's children shown on your form			

Does this parent pay court-ordered child support? Yes No If yes, how much per month do they pay? \$ _____

Section 4: Employment List current employers for you and your spouse, if legally married. Use a separate sheet if you have more employers.

Your current employer/company name	Phone number	Hire date	Spouse current employer/company name	Phone number	Hire date

Section 5: Family Income Family Income Reporting Form – Show gross amounts (before taxes) on this form.

Have you changed employers in the last 12 months? Yes No Has your income changed in the last 12 months? Yes No

Briefly explain change(s) _____

If you have not received a full 30 current/consecutive days of income or benefits from any source of income you listed below, please explain why here.
Also explain any periods for which you don't have documentation.

Basic Health may average or use your last 30 days' income to get the most accurate picture of your income.

You must check "yes" or "no" for each family member on every income line item. Show gross monthly amounts. If more dependents, list on a separate sheet or copy this form.	Self	Spouse	Child
Gross wages, salary, tips, assistantships, commissions	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$
Self-employment or rental income Provide Washington State Unified Business Identifier (UBI) # _____ Check box if no UBI # <input type="checkbox"/> (For details on what to send Basic Health, see the cover letter.)	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$
Unemployment compensation, strike benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	N/A
Social Security benefits - check types received <input type="checkbox"/> Retirement <input type="checkbox"/> Survivor <input type="checkbox"/> Supplemental security (SSI) <input type="checkbox"/> Disability If Social Security disability, date of entitlement _____	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$
Retirements, pensions, annuity benefits Is the amount received due to an early withdrawal? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$
Child support, alimony/spousal maintenance received	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$
Insurance benefits, whether private or through employment, such as life, accident, long- or short-term disability	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$
Interest, dividends, trust, estate, inheritance, capital gains, gambling, lottery, royalties	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$
Veterans benefits, military allotments	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$
Workers' compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$
Public assistance cash grants DO NOT INCLUDE FOOD STAMPS	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$
Income from any other source Explain _____	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$

Section 8: Monthly Expenses (Attach proof)

<input type="checkbox"/> Work or school related child dependent care (including transportation costs)	Monthly amount \$	Who pays
<input type="checkbox"/> Work related adult dependent care (including transportation costs)	Monthly amount \$	Who pays
<input type="checkbox"/> Child support	Monthly amount \$	Who pays

If you do not report any of the above listed expenses, we will consider this as a statement by your household that you do not want to receive a deduction for this expense.

Section 9: Declaration, Agreement, and Signatures

I understand:

- I must give correct information and follow reporting requirements.
- I must provide proof I am eligible, including proof of my gross family income (before taxes and deductions).
- I must assign third party payments for medical care to the State of Washington when I receive medical care benefits. If this would endanger me or someone in my family, then I may ask that medical support and third party payments for medical care not be pursued.
- I must report address changes and changes in my family. For example, my marriage or divorce, or the marriage or divorce of any family member on my account, the birth or adoption of a child, or the date when a child leaves home or is no longer a dependent or is no longer a full-time student.
- My application and the documents I send will be used to determine eligibility for Basic Health and Medicaid programs available in Washington State.
- Basic Health's deposit of my premium payment does not guarantee coverage. The payment will be refunded if I am determined ineligible for coverage.
- If any member of my family, or any person on my behalf, submits false information, my family or I may lose coverage, may be held financially responsible for services obtained or past premium amounts due, and may face other penalties and prosecution.
- Any debt owed to the state may be sent to a collection agency for recovery.
- By signing this form, I have authorized verification of my information and family income with other state or federal agencies or other third-party sources.

I authorize my health plan or medical provider to view medical records for me or my children for purposes of participation in Basic Health or Medicaid programs.

I have read and I understand the information provided to me with this application. I certify or declare under penalty of perjury under the laws of the State of Washington that the information I gave in this application is true and correct.

Agreement must be signed by you and your spouse, if legally married.

Signature of member/applicant	Date	Printed name of member/applicant	City and state where signed
Signature of spouse	Date	Printed name of spouse	City and state where signed

Signature of all dependents age 18 and over

Signature (over age 18)	Date	Printed name	City and state where signed
Signature (over age 18)	Date	Printed name	City and state where signed

Mail required documents to:

Basic Health Recertification
PO Box 42687
Olympia, WA 98504-2687
or FAX: 360-923-2910

Questions?

Call 1-800-660-9840 or visit
www.basicealth.hca.wa.gov

Washington State
Health Care Authority

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